

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-009265

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

1772

STATE FILE NUMBER

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)

Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Missouri b. COUNTY

c. CITY

OR TOWN

Inside Limits

Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location)

HOSPITAL OR INSTITUTION Enroute City Hospital

Inside Limits

Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location)

4053 Olive St.

Reside on Farm

Yes ☐ No ☒

3. NAME OF DECEASED

(Type or print)

First

Middle

Last

Robert Jackson Renfrow (Renfro)

4. DATE OF DEATH

Month

Day

Year

February 15, 1963

5. SEX

Male

6. COLOR OR RACE

White

7. Married ☐ Never Married ☐Widowed ☐ Divorced ☒

8. DATE OF BIRTH

12/5/1918

9. AGE (last birthday)

44

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)

Dixon, Mo.

12. CITIZEN OF WHAT COUNTRY

U.S.

13a. FATHER'S NAME

John Renfrow

13b. MOTHER'S MAIDEN NAME

Belle Lawson

14. NAME OF HUSBAND OR WIFE

Unavailable

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates)

Yes

WW II

16. SOCIAL SECURITY NO.

17. INFORMANT

Earl Renfrow, Iberia, Mo.

18. CAUSE OF DEATH (Enter only one cause)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

Pulmonary Edema; Right Lobe Pneumonia; Myocardial Disease; Pulmonary Edema. 422.2

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal

disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?

YES ☒ NO ☐

20a. ACCIDENT SUICIDE HOMICIDE

☐ ☐ ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour a.m. p.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from

7:05 P.

to

and last saw her

him alive on

Death occurred at

m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

1300 Clair

22c. DATE SIGNED

2-18-63

23a. BURIAL, CREMATION, REMOVAL (Specify)

Removal

23b. DATE

2-18-63

23c. NAME OF CEMETERY OR CREMATORY

Lawson Cemetery

23d. LOCATION (City, town, or county)

Miller Co., Mo.

24. FUNERAL DIRECTOR

ADDRESS

Scrivner-Stevenson, Iberia, Mo.

25. DATE RECD. BY LOCAL REG.

FEB 18 1963

26. REGISTRAR'S SIGNATURE

Earl Smith, M.D.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBONVS 300
Rev. 4/59

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91

DATE AMENDED

7-2

MAR 8 1988

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Harvey Kahle

Licensed Embalmer No. 4596

P. O. Address St Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.